Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

NURSE DELEGATION: ASSUMPTION OF DELEGATION

RESIDENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (MM/DD/YYYY)	CLIENT ID NUMBER

FACILITY NAME	FACILITY'S LICENSE NUMBER

FACILITY'S ADDRESS	CITY	STATE

NAME OF FACILITY OWNER/MANAGER	TELEPHONE NUMBER

☐ 1. Reason/dates for another RN to assume delegating responsibility.

☐ Temporary ☐ Permanent Date From: _____ Date To: _____

☐ 2. I agree that I know the resident through my assessment, the plan of care, the skills of the nursing assistant, and the delegated task. I agree to assume responsibility and accountability for this delegated task and to perform the nursing supervision.

☐ 3. The resident has been given a choice of providers.

☐ 4. The nursing assistant, case manager and resident have been informed of this change.

ASSUMING RN'S SIGNATURE	DATE	RELINQUISHING RN'S SIGNATURE

DSHS 13-678B (REV. 12/2002) (AC 01/2003)

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078 Toll Free.

COPIES: Original - Record Copy - RN Delegator Copy - Other